MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, March 18, 2004
10:06 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Public comment period #1

DR. REISCHAUER:

We now have a few minutes for a public comments. As is always the case, identify yourself, keep your comments brief, and please don't repeat what others have said before you.

MR. THORWARTH: I'll do my best. My name is still Bill Thorwarth. I'm a practicing a diagnostic radiologist from Hickory, North Carolina and currently president of the American College of Radiology. I'd like to congratulate MedPAC first of all for addressing this issue or this group of issues, and the presenters for a good summary of those issues that need to be addressed.

Why do I say that? Radiologists are commonly viewed as the reason for this increased imaging cost. I think as has been pointed out, radiologists do examinations that are requested and referred by other physicians and therefore really are not at the heart of that particular expansion. I'm glad to hear the active evaluation and discussion on the issues regarding self-referral with regards to exactly where the expansion and growth of imaging services is.

The American College of Radiology's slogan is quality is our image, and has long been in the business of promoting the right test by qualified providers at a high-quality facility. These product, overseen by our commission on quality and safety include what are known as appropriateness criteria, a group of 190 different clinical indications with 900 variations of those indications as far as what kinds of tests are appropriate and effective in those clinical circumstances.

The second component of that is the practice guidelines and technical standards defining those requirements for facilities, technologists and physicians who can then perform the tests in a quality fashion.

Then the final is accreditation. Not unlike mammography accreditation that's mandated under the Mammography Quality Standards Act, we have accreditation programs in other things such as MR where right now half the MR facilities units in the country are accredited through the American College.

I think that high-quality imaging has got to be recognized as, it can often result in an overall decrease in a cost of care per episode. Two very common circumstances are abdominal trauma that presents in the emergency room that commonly used to go to laparotomy for exploratory laparotomy to determine if there was a significant injury.

Now CT can very effectively determine which are candidates who can be treated conservatively, which treated operatively. Likewise, MRI of the joints can often times give, in fact most of the time gives accurate detail as to which patients can be treated by conservative management versus operative management.

I had two responses to specific comments that were made during the discussion. First, the comment about efficiencies of multiple studies as one of the strategies to potentially decrease cost. I think that it's important to recognize that there may be an efficiency we talked about -- there was mention of a CT scanner where the patient stays on two minutes longer and has another contiguous anatomic part examined.

I think that it's important to recognize that the efficiency may be in the technical component side of the acquisition of that study but does not necessarily transfer to the professional component side, simply because if I'm reading an ankle x-ray and a foot on two different patients or I'm reading an ankle and a foot on the same patient, I'm still basically reading the same number of films. If I'm reading a CT scan of the pelvis on a patient that just had an abdominal CT, the only efficiency to me is I don't have to say their name twice. I still have to examine all the images. In fact the finding in the second exam may require that I go back and re-examine the first exam to see if there's a related finding in that first exam.

So as the Commission considers this concept of efficiency in multiple imaging exams I wanted to stress that there is really a difference between efficiencies gained in the technical side versus efficiency in the professional side.

Then final comment about radiologists being consultants and examining a patient and trying to recommend a better tests for a given patient. Personally, if I call my orthopedist and I tell him that I've examined his patient's shoulder and he doesn't need an MRI and he needs such and such, I'm not going to make it very far. I think the concept that the radiologists know best what imaging test answers what clinical question best is true. So if the referring physicians provide us with the appropriate clinical history we can guide them to the appropriate and most cost-effective way to work up that particular clinical condition. But I think the likelihood -- first of all there's no value placed in any of the imaging procedures that include E&M values of going to examine patients.

Secondly, I think, as I mentioned before, our overriding a clinician who's done a full E&M evaluation, may have been taking care of that patient for months, for me to override that would be really impossible.

So the college stands ready to work with MedPAC and with CMS to solve this very real issue of expanding imaging costs, and I appreciate the opportunity to comment.

DR. REISCHAUER: Thank you. We stand adjourned for lunch and we'll reconvene at 1:15.

[Whereupon, at 12:24 p.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day.]